

“Explained by Brain” Participant Referral form

Please complete the following and return it with your signed consent form to
jumpstartpsychology@gmail.com

About you:

Name:	
Preferred name:	
DOB:	
Address:	
Email:	
Mobile Number:	
Do you identify as:	Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/>
How did you hear about this group:	Facebook <input type="checkbox"/> NOFASD <input type="checkbox"/> FASDHub <input type="checkbox"/> Internet search <input type="checkbox"/> Word of mouth <input type="checkbox"/> JumpStart Psychology Website <input type="checkbox"/> Other <input type="checkbox"/>
I am parenting: (tick all applicable)	On my own <input type="checkbox"/> With a partner <input type="checkbox"/> Shared parenting <input type="checkbox"/> Other <input type="checkbox"/> Not currently parenting <input type="checkbox"/>
Employment:	Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Casual <input type="checkbox"/> Registered carer with Centalink <input type="checkbox"/> I provide full-time care for my children and am not working outside the home currently <input type="checkbox"/>

About your Child/children:

Please complete the following for each child/young person who lives with you.	How many children/young people live with you?
<p>Child 1 DOB: _____ Gender: _____ Diagnosed with FASD? Yes <input type="checkbox"/> No <input type="checkbox"/> When diagnosed: _____ Age at diagnosis: _____</p> <p>Suspected of having FASD? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Does this child have any other special care needs? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes provide details: _____</p> <p>Is this your biological child? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this child is adopted or under a formal care order? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this the child of another family, community member or friend? Yes <input type="checkbox"/> No <input type="checkbox"/> How long has this child been in your care? _____</p> <p>Does this child identify as: Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/></p>	<p>Child 2 DOB: _____ Gender: _____ Diagnosed with FASD? Yes <input type="checkbox"/> No <input type="checkbox"/> When diagnosed: _____ Age at diagnosis: _____</p> <p>Suspected of having FASD? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Does this child have any other special care needs? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes provide details: _____</p> <p>Is this your biological child? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this child is adopted or under a formal care order? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this the child of another family, community member or friend? Yes <input type="checkbox"/> No <input type="checkbox"/> How long has this child been in your care? _____</p> <p>Does this child identify as: Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/></p>

<p>Child 3 DOB: _____ Gender: _____ Diagnosed with FASD? Yes <input type="checkbox"/> No <input type="checkbox"/> When diagnosed: _____ Age at diagnosis: _____</p> <p>Suspected of having FASD? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Does this child have any other special care needs? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes provide details: _____</p> <p>Is this your biological child? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this child adopted or under a formal care order? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this the child of another family, community member or friend? Yes <input type="checkbox"/> No <input type="checkbox"/> How long has this child been in your care? _____</p> <p>Does this child identify as: Aboriginal <input type="checkbox"/> Torres Straight Islander <input type="checkbox"/> Both <input type="checkbox"/></p>	<p>Child 4 DOB: _____ Gender: _____ Diagnosed with FASD? Yes <input type="checkbox"/> No <input type="checkbox"/> When diagnosed: _____ Age at diagnosis: _____</p> <p>Suspected of having FASD? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Does this child have any other special care needs? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes provide details: _____</p> <p>Is this your biological child? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this child adopted or under a formal care order? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this the child of another family, community member or friend? Yes <input type="checkbox"/> No <input type="checkbox"/> How long has this child been in your care? _____</p> <p>Does this child identify as: Aboriginal <input type="checkbox"/> Torres Straight Islander <input type="checkbox"/> Both <input type="checkbox"/></p>
<p>Child 5 DOB: _____ Gender: _____ Diagnosed with FASD? Yes <input type="checkbox"/> No <input type="checkbox"/> When diagnosed: _____ Age at diagnosis: _____</p> <p>Suspected of having FASD? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Does this child have any other special care needs? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes provide details: _____</p> <p>Is this your biological child? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this child adopted or under a formal care order? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this the child of another family, community member or friend? Yes <input type="checkbox"/> No <input type="checkbox"/> How long has this child been in your care? _____</p> <p>Does this child identify as: Aboriginal <input type="checkbox"/> Torres Straight Islander <input type="checkbox"/> Both <input type="checkbox"/></p>	<p>Child 6 DOB: _____ Gender: _____ Diagnosed with FASD? Yes <input type="checkbox"/> No <input type="checkbox"/> When diagnosed: _____ Age at diagnosis: _____</p> <p>Suspected of having FASD? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Does this child have any other special care needs? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes provide details: _____</p> <p>Is this your biological child? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this child adopted or under a formal care order? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this the child of another family, community member or friend? Yes <input type="checkbox"/> No <input type="checkbox"/> How long has this child been in your care? _____</p> <p>Does this child identify as: Aboriginal <input type="checkbox"/> Torres Straight Islander <input type="checkbox"/> Both <input type="checkbox"/></p>
<p>If you need more spaces please reprint this page and add more children as needed.</p>	

The biggest challenges I face with parenting my child/ren with FASD/suspected FASD include:

The biggest strengths of my child/ren with FASD/suspected FASD are:

Topics I would like to see covered in the group include:

I agree to provide the above information and give consent for JumpStart Psychology to contact me regarding my referral to the “Explained by Brain” group.

Name: _____

Signature: _____

Date: _____

What happens now?

Once your information has been received it will be reviewed and added to our database. You will be mailed some additional questionnaires that will help us to better understand you, your child and your needs. This will also form part of the ongoing evaluation of the group. Questionnaires will be administered at later times also. You may be contacted by JumpStart Psychology to provide more information to ensure that the group is a suitable service for you. Please note that this is a psycho-educational group not a personal therapy group.